PHYSICIAN AUTHORIZATION FORM

Student Name: Please return to:

Date of Birth:

Primary Educational Disability:

Physician:

Health related services included in this child's IEP for one year from _____through _____.

	Services	***How Long***	***How Often***
_____	Developmental & Assistive Therapy (Services provided in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor/fine motor skills development. Services include the application of techniques and methods designed to overcome disabilities, improve cognitive skills and modify behavior.)	_____	_____
_____	Medical Consultation	_____	_____
_____	Mental Health Counseling	_____	_____
_____	Nutrition Services	_____	_____
_____	Occupational Therapy	_____	_____
_____	Personal Care	_____	_____
_____	Physical Therapy	_____	_____
_____	Rehabilitative Nursing Services	_____	_____
_____	Speech, Hearing & Language Services	_____	_____
_____	Vision Care Services	_____	_____

I have reviewed these health-related services and certify that they are medically necessary.

_____ _____
Physician's Signature Date

Primary Medical Diagnosis (optional): _____

 Date Received by Supervisory Union:_____